CPT/HCPCS Modifiers

[Refer to WAC 388-531-1850(10) and (11)]

Italics indicate additional DSHS language not found in CPT©.

22: **Unusual Procedural Services**: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure code number. *This modifier is not to be used to report procedure(s) complicated by adhesion formation, scarring, and/or alteration of normal landmarks due to late effects of prior surgery, irradiation, infection, very low weight or trauma.*

For informational purposes only; no extra allowance is allowed.

23: **Unusual Anesthesia**: *For informational purposes only; no extra allowance is allowed.*

24: **Unrelated Evaluation and Management (E&M) by the Same Physician During a Postoperative Period**: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) ***unrelated*** to the original procedure. This circumstance may be reported by adding the modifier 24 to the appropriate level of E&M service. *Payment for the E&M service during postoperative period is made when the reason for the E&M service is unrelated to original procedure.*

25: **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure**: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the client's condition required a significant, separately identifiable E&M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. This circumstance may be reported by adding the modifier 25 to the appropriate level of E&M service. *Payment for the E&M service is the billed charge or the DSHS/HRSA maximum allowable, whichever is less.*

26: **Professional Component**: Certain procedures are a combination of professional and technical components. When only the professional component is reported, the service is identified by adding modifier 26 to the procedure code.

32: **Mandated Services**: *For informational purposes only; no extra allowance is allowed.*

47: **Anesthesia By Surgeon**: *Not covered by DSHS.*

50: **Bilateral Procedure**: Unless otherwise identified in the listing, bilateral procedures that are performed at the same operative session should be identified by adding this modifier to the appropriate five-digit code describing the first procedure.

For surgical procedures typically performed on both sides of the body, payment for the E&M service is the billed charge or the DSHS/HRSA maximum allowable, whichever is less.

For surgical procedures that are typically performed on one side of the body, but performed bilaterally in a specific case, payment is 150% of the global surgery fee for the procedure.

51: **Multiple Procedures**: *When multiple surgeries are performed at the same operative session, total payment is equal to the sum of the following: 100% of the highest value procedure; 50% of the global fee for each of the second through fifth procedures. More than five procedures require submission of documentation and individual review to determine the payment amount.*

52: **Reduced Services**: Under certain circumstances, a service or procedure is partially reduced at the physician's discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. *Using this modifier does not reduce the allowance to the provider. Note: Modifier 52 may be used with computerized tomography procedure codes for a limited study or a follow-up study.*

53: **Discontinued Procedure**: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.

Use of modifier 53 is allowed for all surgical procedures. Modifier 53 is a payment modifier when used with CPT code 45378 and HCPCS codes G0105 and G0121 only. It is "information only" for all other surgical procedures.

54, 55, 56 – Providers providing less than the global surgical package should use modifiers 54, 55, & 56. *These modifiers are designed to ensure that the sum of all allowances for all practitioners who furnished parts of the services included in a global surgery fee do not exceed the total amount of the payment that would have been paid to a single practitioner under the global fee for the procedure. The payment policy pays each physician directly for that portion of the global surgery services provided to the client. The breakdown is as follows:*

54: **Surgical Care Only**: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number. *A specific percentage of the global surgical payment in the fee schedule is made for the surgical procedure only.*

55: **Postoperative Management Only**: When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier 55 to the usual procedure number. *A specific percentage of the global surgical payment in the fee schedule is made for the surgical procedure only.*

56: **Preoperative Management Only**: When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding the modifier 56 to the usual procedure number. *A specific percentage of the global surgical payment in the fee schedule is made for the surgical procedure only.*

57: **Decision for Surgery**: An evaluation and management (E&M) service provided the day before the day of surgery that resulted in the initial decision to perform the surgery, may be identified by adding the modifier 57 to the appropriate level of E&M service. *This does not apply to minor surgeries (those with a follow-up period of less than 90 days).*

58: **Staged or Related Procedure or Service by the Same Physician During the Postoperative Period**: The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier 58 to the staged or related procedure. *NOTE: This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.*

59: **Distinct Procedural Service**: The physician must indicate that a procedure or service was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, separate lesion, or separate injury (or area of surgery in extensive injuries). *This modifier is for informational purchases only; no extra allowance is allowed.*

62: **Two Surgeons**: Under certain circumstances, the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. Under such circumstances, separate services may be identified by adding modifier 62 to the procedure code used by each surgeon for reporting his/her services. *Payment for this modifier is 125% of the global surgical fee in the fee schedule. The payment is divided equally between the two surgeons. No payment is made for an assistant surgeon.*

66: **Team surgery**: *For informational purposes only; no extra allowance is allowed.*

76: **Repeat Procedure by Same Physician**: The physician may need to indicate that a procedure or service was repeated. This may be reported by adding the modifier 76 to the repeated service.

77: **Repeat Procedure by Another Physician**: *For informational purposes only; no extra allowance is allowed.*

78: **Return to the Operating Room for a Related Procedure During the Postoperative Period**: The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier 78 to the related procedure. ***When multiple procedures are performed, use modifier 78 on EACH detail line.*** *Payment for these procedures is the percentage of the global package for the intra-operative services. Assistant surgeons and anesthesiologists must use modifier 99 to indicate an additional operating room procedure.*

79: **Unrelated Procedure or Service by the Same Physician During the Postoperative Period**: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier 79.

80: **Assistant Surgeon**: Surgical assistant and/or physician assistant services must be identified by adding modifier 80 to the usual procedure code(s). *A physician assistant, employed by a physician, must use the physician's provider number and must bill on the same claim form as the physician/surgeon. Payment is 20% of the maximum allowance.*

81: **Minimum Assistant Surgeon**: Minimum surgical assistant services are identified by adding the modifier 81 to the usual procedure number. *Payment is 20% of the maximum allowance.*

82: **Assistant Surgeon (When Qualified Resident Surgeon Not Available)**: The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s). *Payment is 20% of the maximum allowance.*

90: **Reference (Outside) Laboratory**: When laboratory procedures are performed by a lab other than the referring lab, the procedure must be identified by adding modifier 90 to the procedure code. *The reference lab provider number must be entered in the performing number field on the 1500 Claim Form or electronic claim record. The reference lab must be CLIA-certified.*

91: **Repeat Clinical Diagnostic Laboratory Test** performed on the same day to obtain subsequent report test value(s). *Modifier 91 must be used when repeat tests are performed on the same day, by the same provider to obtain reportable test values with separate specimens taken at different times, only when it is necessary to obtain multiple results in the course of treatment. When billing for a repeat test, use modifier 91 with the appropriate procedure code.*

99: **Multiple Modifiers**: Under certain circumstances, two or more modifiers may be necessary to completely describe a service. *Modifier 99 must be used **when two or more modifiers affect pricing.** All applicable modifiers **must** be listed in the modifier field of the HIPAA transaction (field 24D of CMS-1500). **Modifier 99 must be the first modifier listed on the claim.***

FP Service provided as part of Family Planning Program.

HA Child/Adolescent program

LT **Left Side**: Used to identify procedures performed on the left side of the body. *HRSA requires this modifier with some procedure codes for proper payment.*

QP **Documentation is on file showing that the lab test(s) was ordered individually or ordered as a CPT recognized panel other than automated profile codes**. *This modifier is now used **FOR INFORMATION ONLY**. Internal control payment methodology for automated multi-channel test is applied. This modifier is **not** appropriate to use when billing for repeat tests or to indicate not as a panel.*

Q6 **Physician Services**: Services furnished by a locum tenens physician. *For informational purposes only; no extra allowance is allowed.*

RT **Right Side**: Used to identify procedures performed on the right side of the body. *HRSA requires this modifier with some procedure codes for proper payment.*

SL **State-supplied Vaccine**: *This modifier must be used with those immunization procedure codes indicated in section C to identify those immunization materials obtained from the Department of Health (DOH).*

ST Related to Trauma or Injury

TC: **Technical Component**: Certain procedures are a combination of professional and technical components. When only the technical component is reported, the service is identified by adding modifier TC to the procedure code. *In order to receive payment, a contract with HRSA is required if services are performed in a hospital setting.*

TG **Complex/high level of care.**

TH **Obstetrical treatment/services, prenatal or postpartum**: *To be used only for those maternity services outlined in Section H [e.g. antepartum care requiring only 1-3 visits (CPT codes 99201-99215 TH) and labor management (CPT codes 99221-99223 TH)].*

TJ **Child/Adolescent Program GP**: *To be used for enhancement payment for foster care children screening exams.*

TS **Follow-up service:** *To be used only with HCPCS procedure code H0009.*

UA **M/Caid Care Lev 10 State Def**.

UN **Two patients served:** *To be used only with CPT code R0075.*

UP **Three patients served:** *To be used only with CPT code R0075.*

UQ **Four patients served:** *To be used only with CPT code R0075.*

UR **Five patients served:** *To be used only with CPT code R0075.*

US **Six or more patients served:** *To be used only with CPT code R0075.*

Anesthesia Modifiers

AA Anesthesia services personally furnished by an anesthesiologist. *This includes services provided by faculty anesthesiologists involving a physician-in-training (resident). Payment is 100% of the allowed amount. Modifier AA must not be billed in combination with QX.*

When supervising, the physician must use one of the modifiers below. Payment for these modifiers is 50% of the allowed amount. Modifier QX must be billed by the Certified Registered Nurse Anesthetist (CRNA).

AD Medical supervision by a physician for more than four concurrent anesthesia services.

QK Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.

QS Monitored anesthesia services. ***This modifier is not covered by HRSA.***

To bill for monitored anesthesia care services, the following applies:

If the physician personally performs the case, modifier AA must be used and payment is 100% of the allowed amount.

If the physician directs four or fewer concurrent cases and monitored care represents two or more of the case modifiers, modifier QK must be used and payment is 50% of the allowed amount.

QX CRNA service with medical direction by a physician should be used when under the supervision of a physician. *Payment is 50% of the allowed amount. This modifier is payable in combination with Modifiers AD or QK, which is used by the supervising anesthesiologist. Modifier QX must not be billed in combination with AA.*

QY CRNA and anesthesiologist are involved in a single procedure and the physician is performing the medical direction. *The physician must use modifier QY and the medically directed CRNA must use modifier QX. The anesthesiologist and CRNA each receive 50% of the allowance that would have been paid had the service been provided by the anesthesiologist or CRNA alone.*

QZ CRNA service without medical direction by a physician. *Must be used when practicing independently. Payment is 100% of the allowed amount. This modifier must not be billed in combination with any other modifier.*